

Medicaid Reimbursement for Community-Based Prevention

Based on Convening Held October 31, 2013

Background

The Affordable Care Act is driving change in our health care system. Delivery system reforms are aimed at making health care providers more accountable for quality and health outcomes. Financing reforms are shifting the reimbursement system from volume-based to value-based. A highly coordinated health care system will be critical for addressing our nation's chronic disease burden, which today accounts for roughly 75 percent of our health care spending. Evidence of effective community-based prevention programs is mounting¹, and studies show that investment in community-based prevention yields savings on a magnitude of more than 5 to 1.² The Prevention and Public Health Fund has funded new and expanded evidence-based community-based prevention programs, building on years of experience and activities at the Centers for Disease Control and Prevention (CDC).

Issue

Uptake of community-based prevention programs has been hampered by a lack of reimbursement for these activities. Public and private insurers have traditionally focused on reimbursing services provided by licensed clinical providers in a health care setting. The focus on population health is driving changes in the marketplace related to the need for a broader array of health professionals to provide preventive services. The Trust for America's Health *Healthier America 2013* report recommended that the Centers for Medicare and Medicaid Services (CMS) "clarify states' ability to reimburse a broader array of health providers and pay for additional covered services" under Medicaid. Nemours' paper on "Medicaid Funding of Community-Based Prevention" highlighted this as well as other authority under Medicaid that would allow payment for prevention services.³

Opportunity

CMS recently changed⁴ Medicaid regulations to better align with the existing Medicaid statute.⁵ The change clarifies that states can reimburse for preventive services "recommended by a physician or other licensed practitioner...within the scope of their practice under State law". Previously, states could only cover preventive services that were provided by a licensed practitioner. This change opens the door to Medicaid reimbursement for preventive services staffed by a broad array of health professionals, including those that may fall outside of a state's clinical licensure system. Examples of services by non-licensed providers that could potentially be reimbursable, some of which are currently covered in Medicaid managed care or other plans include:

- Care coordination and educational counseling⁶
- Home visiting
- Group health education (potentially reimbursable as long as Medicaid enrollees have some one-on-one interaction with the counselor)
- Community health worker services⁷, such as asthma education to Medicaid enrollees
- Lactation consultation
- Developmental screening done by trained consultants in child care centers
- YMCA diabetes prevention program
- Science-informed parenting education

CMS staff clarified that this rule does not change the definition of eligible preventive services under Medicaid or Early and Periodic Screening, Diagnostic and Treatment (EPSDT). States will have to submit a State Plan Amendment if they want to take up this option, describing: what services will be covered; who will provide them and "any required education, training, experience, credentialing or registration"⁸ of these providers; the state's process for qualifying providers; and the reimbursement methodology.

This rule change is one of several opportunities for promoting prevention through delivery reform in Medicaid, along with Section 1115 and targeted waivers, delivery reform pools, shared savings programs and other changes implemented through state plan amendments. Other areas for consideration, where States have demonstrated success in navigating Medicaid rules to finance prevention initiatives, include reimbursement for: (1) Medicaid preventive services delivered to Medicaid enrollees in non-traditional settings; (2) non-medical services to Medicaid enrollees; (3) services delivered to non-Medicaid beneficiaries (e.g. parents of Medicaid beneficiaries); and (4) benefits that are delivered on a non-state-wide basis.⁹ States also have the option to cover U.S. Preventive Services Task Force (USPSTF) A and B recommended clinical preventive services and receive an additional 1 percent in their Federal Medicaid Assistance Percentage (FMAP). Medicaid and public health can work together to develop these programs in states.

Barriers and Issues to Address

While the rule change presents an important opportunity for enhancing the focus on prevention through the Medicaid program, there are barriers to implementation that must be considered and addressed.

Examples of these barriers include:

- Addressing State Medicaid agency bandwidth, churning and competing priorities
- Implementing safeguards to prevent fraud and abuse
- Addressing tensions regarding scope of practice issues from licensed providers
- Educating providers about this change and working with them to develop referral relationships with new providers/programs
- Determining how to bill
- Engaging managed care since the rule is applicable to fee-for-service Medicaid

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Uptake and Implementation

As States turn their focus to improving population health, and since community prevention programs provided by a broader array of health professionals generally have not previously been reimbursed by Medicaid, new tools and methods are needed to help in the implementation process. Creating tools and templates to assist advocates and States as they assess this opportunity will be critical. The attached questionnaire created by Nemours is designed to prepare advocates to engage in a dialogue with their State Medicaid officials about pursuing this new option. States have a variety of priorities related to Medicaid and will likely not focus on this provision unless they are presented with clear and compelling proposals that answer the key questions below.

What do state Medicaid agencies need to facilitate uptake of community prevention services performed by qualified providers?

1. A rationale for the health goal or gap they want to address.
2. An explanation of why this provision is an appropriate tool to achieve that goal and whether it should be combined with other CMS policy levers.

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3. Examples and the evidence to determine what services should be covered (to identify what the benefits will be). States might initially consider interventions meeting a high standard of evidence, in clinical settings where a team is already in place (and thus the community-based provider would be an expansion of the team, supporting licensed providers who can then operate at the "top of their license") and in a clinical area that has clearly established clinical guidelines. States may also wish to prioritize interventions in high costs areas and interventions with a well-documented return on investment (ROI).
4. A process to determine which providers can deliver a quality service.
 - a. States must develop minimum training and qualifications for the providers and should identify linkages to primary care. Providers will need to coordinate with the referring clinician. This model currently exists in Medicaid rehabilitation services.
 - b. One possibility is the home health model where an organization hires, trains and is responsible for the workers and the agency would bill Medicaid.
 - c. Another possibility would be a health care provider hires trained workers and integrates them as part of their care teams.
5. Methods for monitoring the delivery of services to ensure service quality and program integrity
6. A template to determine if they have all the information needed to submit a State Plan Amendment

What do providers need to seize this opportunity to improve the health of their Medicaid patients?

1. Referral systems. Some states and communities are beginning to develop open-source, bi-directional electronic referral programs to enable electronic community-clinical linkage
2. Feedback loops between referring providers and those delivering community-based prevention services.
3. Awareness. States that take up this option will need to educate their provider community to begin making the referrals to community-based providers.

Areas for Further Exploration

A variety of topics related to this rule present additional opportunities for exploration. The ways in which these issues are resolved will play a role in the ultimate success of the implementation of the rule and could be pursued on a parallel track.

1. Population health metrics
2. Workforce, including duties, training and qualifications
3. E-referring and data sharing between clinical and community providers
4. How to build capacity in communities/states to seize these opportunities
5. Braiding opportunities. States may want have Medicaid cover a certain percentage of the costs and get someone else to fund the rest.

Medicaid Provision of Preventive Services Regulation Questionnaire

Updated by Nemours March 28, 2014

Effective January 1, 2014, the Centers for Medicare and Medicaid Services (CMS) revised the definition of preventive services in 42 CFR §440.130(c) to allow states the option to cover preventive services recommended by physicians or other licensed providers to be provided by practitioners other than physicians or other licensed practitioners. The former version of the regulation required preventive services to be provided by a physician or other licensed practitioner. States that choose to move forward will need to submit a Medicaid State Plan Amendment (SPA) to CMS. The rule change is one of several opportunities promoting prevention through Medicaid. The focus on population health is driving changes in the marketplace related to the need for a broader array of health professionals to provide preventive services.

This questionnaire is designed to prepare organizations to engage in a dialogue with their state Medicaid officials about pursuing the new option to cover preventive services provided by non-licensed professionals under 42 CFR §440.130(c). State Medicaid agencies will likely need the information identified in the questionnaire to prepare a Preventive Services SPA and may have additional questions. Interested organizations are encouraged to answer as many questions as possible and be prepared to be as specific as possible in describing their proposal.

Background

The new option only relates to services provided under the Medicaid preventive services benefit authorized under 42 CFR §440.130 (c). It does not change the definition of covered preventive services under Medicaid. Section 4385 of the State Medicaid Manual, which represents CMS' guidance on 42 CFR §440.130 (c), which makes clear that Medicaid-covered preventive services must (1) involve direct patient care and (2) be for the express purpose of diagnosing, treating or preventing (or minimizing the adverse effects of) illness, injury or other impairments to an individual's physical or mental health. The regulation does not change current federal authority which allows states the option to pay for preventive services provided outside the clinical setting.

This regulation applies to Medicaid services provided fee-for-service under a State Plan Amendment. Many states provide Medicaid services through managed care organizations (MCOs). While MCOs already have flexibility to pay non-licensed professionals for preventive services, there are a number of reasons many do not, most notably they may not be required to provide the services and the costs may not be reflected in their capitation payments. Nonetheless, it is important to consider the availability of preventive services provided by these providers to managed care enrollees. States will need to consider the relationship between the State Plan Amendment change and their MCO requirements, including such strategies as requiring MCOs to mirror the requirements in the State Plan.

The rule change is one of several opportunities for promoting prevention through Medicaid. Some states have implemented new Medicaid financing and delivery models designed to improve health, health care and lower costs under initiatives approved by the Center for Medicare and Medicaid Innovation (CMMI). These new models may be opportunities to leverage new flexibility and financial incentives to improve access to prevention services. These new options build on the demonstrated success of public

health and Medicaid leaders in some states to navigate Medicaid's complex requirements to finance community-based prevention initiatives.¹⁰

While the rule change presents an important opportunity for enhancing the focus on prevention through the Medicaid program, there are barriers to implementation that must be considered and addressed.

Examples of these barriers include:

- Addressing State Medicaid agency bandwidth, churning and competing priorities.
- Implementing safeguards to prevent fraud and abuse.
- Addressing tensions regarding scope of practice issues from licensed providers.
- Educating providers about this change and working with them to develop referral relationships with new providers/programs.
- Determining how to bill.
- Engaging managed care since the rule is applicable for fee-for-service Medicaid.
- Determining (with input from the CMS Regional Office for your state) that the services proposed to be covered meet the specific CMS definition of 'preventive services'.

Questions to Consider When Defining the Proposal

A. Basic Description

1. **Provider**: What type of provider(s) are you proposing to use?
2. **Service**: What services would the provider(s) be providing? (See section 4385 of the State Medicaid Manual for guidance on the definition of preventive services.) CMS' rule change did not expand the types of services that can be covered as preventive services. Therefore, services that are not coverable under the preventive services regulation would have to be addressed under a different federal authority.
3. **Eligible Individual**: What Medicaid-covered individuals would receive this service?

Note: Medicaid is a program that pays for covered services, provided to individuals enrolled in Medicaid by eligible Medicaid providers. It is important to keep this basic framework in mind when describing the proposal.

B. Requirements for Providers Who Are Not Physicians or Licensed Practitioners

1. **Educational Background**: What are the educational requirements for each type of provider?
2. **Training**: What type of training and continuing education would the provider have to complete? Who would provide the training? How will you document training has been completed?
3. **Experience**: What experience would each type of provider be required to have?
4. **Credentialing or Registration Process**: Which state agency would be responsible for certifying that providers have met all the requirements? How does the Medicaid program confirm the provider has met the established requirements and register the provider(s) in their payment systems (for example, provide a Medicaid provider number)? Can a third party attest to the qualifications of the providers?
5. **Employment**: Who would employ the provider(s) (for example, solo practitioner, employed by agency, employed by a health provider as part of a team)?

C. Covered Services (Service Definition, Referral and Coordination)

1. **Defined Service(s)**: What preventive service(s) would the provider(s) be authorized to offer? (See section 4385 of the State Medicaid Manual for guidance.)
2. **Referral**: What is the process by which a physician or other licensed practitioner would recommend a service? How would the referral from a physician or other licensed practitioner be documented?
3. **Service Limitations**: Are there any limitations on the number of services provided? Are there any limitations or requirements on the location in which the service may be provided?
4. **Follow-up**: What type of follow-up would occur with the referring physician or other licensed practitioner to ensure care coordination and integration?
5. **Reimbursement**: What would the unit of service be? How would the reimbursement level for the service be determined?

D. Eligible Medicaid Members

1. **Establishing Medicaid Eligibility**: What process is in place to document the Medicaid eligibility of the individual who receives the service?
2. **Non-Medicaid**: Would the provider also provide the preventive service to individuals who are not covered by Medicaid? If so, who would pay for that service and what is the level of reimbursement (note: Medicaid generally will not pay for services that are otherwise provided for free)?
3. **Eligibility Limitations**: Are there any limitations on who may receive the services from the provider(s) (for example: age, diagnosis, risk status)?

E. Overall Rationale and Purpose for use of the Provider

1. **Goal**: What is the health care goal or gap that the provider(s) will fill?
2. **Evidence**: It would be helpful to have evidence that the provider can achieve the goals of reducing health care costs and improving health and health care and evidence of return on investment (ROI). What is the evidence of effectiveness of the service?
3. **Cost**: What is the anticipated cost for preventive services provided by this new type of health care provider?

F. Other Issues

1. **Oversight**: What type of oversight, monitoring or evaluation occurs to ensure the quality of the services provided?
2. **Background**: Is this provider currently providing preventive services or is this a new initiative? If currently provided, how is it funded?
3. **Availability**: What is the availability of this provider? How does it vary throughout the State?

¹ http://www.tfah.org/assets/files/Compendium_Report_1016_1131.pdf

² <http://www.tfah.org/reports/prevention08/Prevention08Exec.pdf>

³ Burton, A., Chang, D., and Gratale, D. Medicaid Funding of Community Based Prevention: Myths, State Successes Overcoming Barriers and the Promise of Integrated Payment Models, 2013. Accessible at

http://www.nemours.org/content/dam/nemours/wwwv2/filebox/about/Medicaid_Funding_of_Community-Based_Prevention_Final.pdf

⁴ Final Rule: Medicaid and Children's Health Insurance Program; Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment. Centers for Medicare & Medicaid Services. Section 42 CFR §440.130. 78 Federal Register 42160. July 15, 2013.

See also: <http://www.childhoodasthma.org/wp-content/uploads/2013/07/Medicaid-and-Community-Based-Asthma-One-Pager.pdf>

⁵ Section 1905(a)(13) of the Social Security Act provides for Medicaid payment for "other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level."

⁶ This rule change and other existing levers support care coordination, such as targeted case management and the home health match.

⁷ Burton, A., Chang, D., and Gratale, D. Medicaid Funding of Community Based Prevention: Myths, State Successes Overcoming Barriers and the Promise of Integrated Payment Models, 2013. Accessible at

http://www.nemours.org/content/dam/nemours/wwwv2/filebox/about/Medicaid_Funding_of_Community-Based_Prevention_Final.pdf

⁸ CMS Informational Bulletin - Update on Preventive Services Initiatives, November 27, 2013.

⁹ Burton, A., Chang, D., and Gratale, D. Medicaid Funding of Community Based Prevention: Myths, State Successes Overcoming Barriers and the Promise of Integrated Payment Models, 2013. Accessible at

http://www.nemours.org/content/dam/nemours/wwwv2/filebox/about/Medicaid_Funding_of_Community-Based_Prevention_Final.pdf

¹⁰ Burton, A., Chang, D., and Gratale, D. Medicaid Funding of Community Based Prevention: Myths, State Successes Overcoming Barriers and the Promise of Integrated Payment Models, 2013. Accessible at

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